Chapter One

Introduction

In many ways, the debate over the interaction between health care reform and the pharmaceutical industry represents a more general tension generated by changes in the health care system and the development of new medical technologies. On the one hand, U.S. medicine is the most technologically advanced in the world. The public appreciates this and generally endorses the continued development and provision of high-technology health care. On the other hand, many people feel that health care costs too much and that the rapid pace of technological development is a major contributing factor.

As proposals to restructure the health care system have proliferated, critics have expressed concern about the effects the proposed changes would have on research and development (R&D) and future access to new treatments, including pharmaceuticals and other medical technologies. The quandary facing health care reform efforts can be summed up as a public desire to save the goose that laid the golden eggs, but not to pay too much for the goose.

The desire for profits (or returns) is one of the basic reasons that investors fund the R&D needed to produce new pharmaceuticals and other medical technology. The higher the anticipated returns from technology development, the greater the incentive to invest in the necessary R&D. If changes in the health care system increase the profits from developing new medical technology, firms are likely to increase their investment in it. Conversely, decreases in the returns from developing new medical technology are likely to lower the level of R&D in this field. Thus, reducing costs must be balanced against affording sufficient incentive for drug companies and other providers of medical technology to continue investing in medical progress.

The Administration's proposal, the Health Security Act, could change the returns from pharmaceutical R&D.[1] Although this study analyzes the effect of the Administration's proposal on these returns, many of its conclusions apply to other plans that incorporate the same or similar features. Since other health care proposals are trying to accomplish similar goals, they face many of the same tensions and are likely to use many of the same mechanisms.

Most reform proposals contain three elements that would affect patterns of pharmaceutical use and spending:

- Expanding coverage in the form of new benefits and to new people,
- Shifting people into managed care, and
- Controlling costs.

What economists know about these elements is very spotty. Surveys are available to help quantify the effect of expanded coverage. Little information exists, however, to help predict the effects of a greater shift toward managed care plans or cost control mechanisms on pharmaceutical spending.

1. References to the Administration's proposal are to the Health Security Act, H.R. 3600 and S. 1757, 103rd Congress, 1st Session, 1993. For a more comprehensive analysis of that proposal, see Congressional Budget Office, *An Analysis of the Administration's Health Proposal* (February 1994).

For example, the comparison of the use of pharmaceuticals in fee-for-service health plans with their use in health maintenance organizations is based on one limited study. The dual nature of pharmaceutical consumption--the fact that drugs complement medical treatments as well as substitute for them--also complicates the analysis. Thus, cutting down health costs could lower pharmaceutical demand in one way, but increase it in another.

The Administration's proposal also contains provisions that may affect pharmaceutical demand and are likely to interact with each other as well as with the three elements above. A partial list includes:

- Outpatient prescription drug coverage for Medicare beneficiaries;
- Rebates on outpatient prescription drugs sold to Medicare beneficiaries;
- Special Medicare rebates on new drugs and an Advisory Council on Breakthrough Drugs to examine launch prices;
- An end to rebates on outpatient prescription drugs sold to Medicaid beneficiaries;
- Coverage of some services that are not well covered now by private health plans and have significant drug treatment components (examples include mental health and family planning services);
- Coverage of investigational treatments (such as some experimental drugs for human immunodeficiency virus--HIV--infection);
- Increased out-of-pocket costs for prescription drugs for many current Medicaid beneficiaries; and
- Constraints on the rate of growth of premiums for the standard benefit package.

The combined effect of these provisions on pharmaceutical demand and supply and on the future profitability of pharmaceutical R&D is highly uncertain. The Congressional Budget Office (CBO) cannot realistically provide a quantitative estimate of all the effects of the Administration's proposal on the pharmaceutical market. CBO's analysis examined the first four items on the list, in addition to expanded coverage. In cases where estimates of the quantitative effects could be made, CBO did so. In other instances, the range of uncertainty was too great and CBO made no estimate. Even when quantitative information is available, it must be applied with caution. In sum, the assessments discussed in this study are best considered illustrative and partial estimates of the effects of the Administration's proposal for health care reform on the profits from drug development.